



Tryvio(aprocitentan)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640



MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Pulmonary arterial hypertension(PAH) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>Is patient going to be using drug in a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does patient have uncontrolled blood pressure with a Mean Sitting Systolic Blood Pressure (SiSBP) of greater than or equal to 140mmHg? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Does patient have uncontrolled blood pressure with Mean Sitting Systolic Blood Pressure (SiSBP) of greater than or equal to 140mmHg despite patient being on at least 3 background antihypertensive medications within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Has patient actively been taking at least 3 antihypertensive therapies from different pharmacological classes for at least 4 weeks prior to starting on Tryvio(aprocitentan)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Has patient used add-on spironolactone therapy to their 3 antihypertensive therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Does patient have an absolute contraindication to spironolactone such as chronic kidney disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Does patient have severe hypertension (grade 3) defined as SiSBP greater than or equal to 180 mmHg and/or Sitting Diastolic Blood Pressure (SiDBP) greater than or equal to 110 mmHg? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Has apparent/pseudo Resistant Hypertension (RHT) due to white coat effect, medical inertia, poor therapeutic adherence, or secondary causes of hypertension (except sleep apnea) been ruled out? <input type="checkbox"/> No <i>Please submit documentation.</i></p> <p>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</p> <hr/> <hr/>		
<p>Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.</p>		





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ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program Attn:CP-4201
 P.O.Box 64811
 St. Paul, MN 55164-0811
 Phone: 877-228-7909

